

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF MILITARY AFFAIRS
FRANKFORT, KY 40601-6168

Ky Technician Personnel Regulation
735

1 September 1992

Civilian Personnel

STANDARDS OF CONDUCT FOR NATIONAL GUARD TECHNICIANS
AND
ACTIVE GUARD RESERVE PERSONNEL

Technician Personnel Regulation (TPR) 700(735), contains the requirements for Standards of Conduct for National Guard Technicians. This regulation supplements TPR 700(735) for the Kentucky Army National Guard and Kentucky Air National Guard.

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MEMORANDUM FOR All Permanent and Indefinite Technicians, Kentucky
National Guard

SUBJECT: (KY Log Number I01-010) Charging of Military Leave Under 5 United States Code (U.S.C.) 6323(a)

1. The Consolidated Appropriations Act, 2001, Public Law 106-554, incorporates the Treasury and General Government Appropriations Act (TGGAA), 2001. Section 642 of the TGGAA amends Section 6323(a), 5 U.S.C., by providing that military leave be charged in hourly increments.

2. Effective 21 December 2000, the following guidance applies to the charging of military leave granted under 5 U.S.C. 6323(a):

a. Military leave under Section 6323(a) is charged in hourly increments.

b. Full-time technicians will accrue 120 hours of military leave in a fiscal year. Military leave under 6323(a) will be prorated for part-time employees and employees on uncommon tours of duty based proportionally on the number of hours in each employee's regularly scheduled biweekly pay period.

c. Military leave can only be used for periods of absence from the technician position, to include travel time, to perform military duty.

d. There is no charge to military leave on any holiday or non-workday.

3. The following illustrates the proper charge to leave under the new law:

a. A technician on a regular work schedule after completing his normal technician duty day on Thursday, 1 March 2001, elects to use military leave. The technician completes military duty on Thursday, 15 March, and returns to technician duty on Friday, 16 March. The period of absence charged to leave would be 80 hours (10 x 8). There is no charge to leave for the intervening non-workdays of 3, 4, 10, and 11 March.

Links to view health insurance brochures:

http://www.aetnafeds.com	Aetna
http://www.fepblue.org	Blue Cross Blue Shield
http://www.geha.com	GEHA
http://feds.humana.com	Humana
http://www.mhbp.com	Mailhandlers

The cost for each plan is located on the last page of the brochure under “Non-Postal Biweekly Your Share”



Federal Employees
Health Benefits Program

Form Approved:
OMB No. 3206-0160

Health Benefits Election Form

Part A - Enrollee and Family Member Information (For additional family members use a separate sheet and attach.)

1. Enrollee name (last, first, middle initial)		2. Social Security number		3. Date of birth		4. Sex <input type="checkbox"/> M <input type="checkbox"/> F		5. Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Home mailing address (including ZIP Code)				7. Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		8. TRICARE <input type="checkbox"/>		9. Other insurance <input type="checkbox"/>	
				10. Name of insurance		11. Insurance policy no.			
12. Name of family member (last, first, middle initial)		13. Social Security number		14. Date of birth		15. Sex <input type="checkbox"/> M <input type="checkbox"/> F		16. Relationship code	
17. Address (if different from enrollee)				18. Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		19. TRICARE <input type="checkbox"/>		20. Other insurance <input type="checkbox"/>	
				21. Name of insurance		22. Insurance policy no.			
Name of family member (last, first, middle initial)		Social Security number		Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship code	
Address (if different from enrollee)				Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		TRICARE <input type="checkbox"/>		Other insurance <input type="checkbox"/>	
				Name of insurance		Insurance policy no.			
Name of family member (last, first, middle initial)		Social Security number		Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship code	
Address (if different from enrollee)				Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		TRICARE <input type="checkbox"/>		Other insurance <input type="checkbox"/>	
				Name of insurance		Insurance policy no.			
Name of family member (last, first, middle initial)		Social Security number		Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship code	
Address (if different from enrollee)				Medicare (See note - page 2) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		TRICARE <input type="checkbox"/>		Other insurance <input type="checkbox"/>	
				Name of insurance		Insurance policy no.			

Part B - Present Plan

1. Plan name	2. Enrollment code
--------------	--------------------

Part C - New Plan

1. Plan name	2. Enrollment code
--------------	--------------------

Part D - Event Code

1. Event code	2. Date of event
---------------	------------------

Part E - Employees Only (Election NOT to Enroll)

☐ I do NOT want to enroll in the FEHB Program.
My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation

☐ I CANCEL my enrollment.
My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension (Annuitants/Former Spouses Only)

☐ I SUSPEND my enrollment.
My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

Part H - Signature

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature (do not print)	2. Date (mm/dd/yyyy)	3. Daytime telephone number
----------------------------------	----------------------	-----------------------------

Part I - To be completed by agency or retirement system

REMARKS

1. Date received	2. Effective date of action	3. Personnel telephone number	4. Name and address of agency or retirement system
5. Authorizing official (please print)	6. Signature of authorized agency official		
7. Payroll office number	8. Payroll office contact (please print)	9. Payroll telephone number	

NSN 7540-01-231-6227

This edition supersedes all previous editions of SF 2809 and SF 2809-1.

U.S. Office of Personnel Management

Copy 1 - Official Personnel Folder

Standard Form 2809
Revised October 2004
Previous editions are not usable.

*You can draw upon your FSA
for reimbursement as you incur
eligible expenses – it's there
when you need it.*

SHPS' Role in Administering the Federal FSA Program

SHPS, one of the nation's largest FSA administrators, will assume full responsibility for the day-to-day administration of the HCFA and DCFSA programs. This includes, but is not limited to:

- Communications regarding FSAs and how they work, including communications for the Initial and Open Season enrollment periods. SHPS maintains a dedicated Web site at www.fsafeds.com for Federal employees to access general program information, enroll, and manage their accounts online.
- The FSAFEDS Web site at www.fsafeds.com is always available for access to information at your convenience.
Note: SHPS utilizes encryption technology to protect the privacy of account information.
- Managing the enrollment process, whether you choose to enroll via the Web or call toll-free to a SHPS customer service representative at 1-877-FSAFEDS (1-877-372-3337).
- Answering questions during and after the Initial and Open Season periods. SHPS maintains toll-free customer service between 9:00 AM and 9:00 PM Eastern Time, Monday through Friday, at 1-877-FSAFEDS (1-877-372-3337). An automated telephone service is also available for you to check account balances and the status of your last claim.

Where to Get More Information

SHPS should be your first source of contact. SHPS offers a number of resources that will help you learn more about the Federal FSA program and keep you informed on the latest developments. And whether you choose to go online, or want to speak to a customer service representative, just contact SHPS at any one of the resources below:

Web

Visit the FSAFEDS Web site at
www.fsafeds.com



Phone

Call toll-free at 1-877-FSAFEDS
(1-877-372-3337)



For hearing impaired individuals, call the
FSAFEDS TTY line at 1-800-952-0450.

E-Mail

fsafeds@shps.net



Mail

Write to: FSAFEDS Program
P.O. Box 36880
Louisville, Kentucky 40233-6880



Disclaimer: This brochure provides a general overview of the Federal FSA Program. Please refer to the FSAFEDS Web site at www.fsafeds.com for specifics regarding the plan.

A PATHWAY TO SAVINGS



FSAFEDS ADMINISTRATION
P.O. BOX 36880 / LOUISVILLE, KENTUCKY 40233-6880
877.372.3337 / www.fsafeds.com

DATE PRINTED: 01/2003
OPM FSATRI RUS/2003



Introducing the Federal
Flexible Spending Account
Program for 2003

OPM and SHPS

PARTNERS FOR FLEXIBLE SPENDING ACCOUNTS

Introducing the Federal Flexible Spending Account Program for 2003

OPM and SHPS Partner to Bring Choice to Federal Employees

"Used wisely, flexible spending accounts are effective financial management tools that can stretch the disposable incomes of account holders and ensure that funds are available, when needed, to pay for out-of-pocket medical expenses or the dependent care costs of a child or parent. I am confident that federal employees will benefit from participation in the FSA program and they can be sure that their accounts are being professionally managed by a company experienced with participant reimbursement accounts."

Kay Coles James

Director, US Office of Personnel Management

Highlights of the FSA Program

What is a Flexible Spending Account? A Flexible Spending Account is an employee benefit that allows you to set aside money, on a pre-tax basis, for certain kinds of common expenses. With an FSA, you can reduce your taxes while paying for services you'd have to pay for anyway.

The Federal FSA Program offers:

- *The Health Care Flexible Spending Account (HCFSA)* - for health care expenses not paid by FEHB or any other insurance.
- *The Dependent Care Flexible Spending Account (DCFSA)* - for dependent care expenses that allow you (and your spouse, if married) to work or look for work, or that allow your spouse to attend school full-time.

How does an FSA work?

First, you'll need to determine how much money to allot on an annual basis and make your election(s) with SHPS. For the HCFSA, you can set aside up to \$3,000, and for the DCFSA, you can contribute up to \$5,000 for the Plan Year. SHPS has a number of educational FSA resources, including decision support tools to assist you in deciding how much to contribute.

Second, SHPS requests your payroll office to deduct equal installments of the annual allotment you elect. SHPS then receives your elected amount for deposit into your appropriate account(s).

Third, when you incur an eligible expense, you'll pay for it out of pocket, and then submit a claim for reimbursement to SHPS. All claims must be accompanied by the appropriate documentation, such as an itemized receipt or an explanation of benefits.



FEGLI PROGRAM BOOKLET

For Federal Employees

50TH ANNIVERSARY EDITION

Federal Employees' Group Life Insurance Program

BASIC LIFE +

OPTION A

Standard

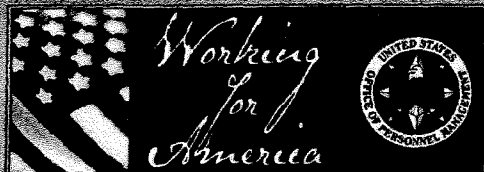
OPTION B

Additional

OPTION C

Family

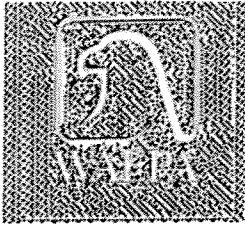
Administered by the
United States Office of Personnel Management



FE 76-21

Revised August 2004

Previous versions (FI 76-21) not usable



Worldwide Assurance for Employees of Public Agencies

WAEPA is a non-profit association, governed by federal employees who on a voluntary basis, providing insurance benefits to civilian federal employees.

\$25,000 or \$50,000 Open Enrollment - Life Insurance

Newly Hired Civilian Federal & USPS Employees
can now qualify for **\$25,000 or \$50,000** of Group Term Life
Insurance

Without Any Medical Examination!

Effective October 1, 2005 all newly hired civilian federal employees who are within six months (180 days) of their original federal hire date can enroll for \$25,000 or \$50,000 of WAEPA life insurance on a guaranteed issue basis. No medical exam or physician records are required! To be eligible new employees must be under the age of 65 and possess US citizenship. Annual Premium follows:



WAEPA Home

WAEPA vs FEGLI

Rates and Benefits

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About WAEPA

WAEPA Guides

WAEPA Calculator

Long Term Care
Insurance from WAEPA

Members Only
Request for Information
& Forms

Site Map

Age	\$25,000 of Coverage	\$50,000 of Coverage
Under 25	\$12.00	\$24.00
25-29	\$15.00	\$30.00
30-34	\$17.00	\$34.00
35-39	\$20.00	\$40.00
40-44	\$28.00	\$56.00
45-49	\$40.00	\$80.00
50-54	\$61.00	\$122.00
55-59	\$93.00	\$186.00
60-64	\$157.00	\$314.00

Plus, at no additional cost...

Accidental Death & Dismemberment*	\$5,000	\$10,000
Additional Accident**	\$10,000	\$20,000

Print the WAEPA Open Enrollment - Life Insurance Form

Eligibility requirements:

- You are a newly hired civilian federal employee.
(Full time members of the armed forces are not eligible)
- You must apply for this coverage within 180 days of your original hire date to
- You are a United States Citizen.
- You are under 65 years of age.

* In Case of Accident

You must apply for this coverage within 180 days of your original hire date to obtain WAEPA provides an additional benefit for accidental death and dismemberment at no cost! The full benefit is payable in the event of accidental death, or the loss of both the entire sight of both eyes, or one hand and one foot, or one hand or one foot and

YOUR ACCEPTANCE TO OUR INSURANCE PLANS IS GUARANTEED

ACT NOW BEFORE SPECIAL
ELIGIBILITY ENDS!

...If you apply during your first 31 days of employment
or if you apply during an official enrollment.

GOOD NEWS!
All benefits described as
GUARANTEED
during certain
times... may be
applied for at any time.

Guaranteed protection for technicians.
No health questions asked if you act during
the Guaranteed Acceptance Period.

Technicians Insurance Program

Details inside.

The only plans endorsed by the
National Guard Association of the United States, and the
Enlisted Association of the National Guard of the U.S.





NATIONAL GUARD ASSOCIATION OF THE UNITED STATES OPEN ENROLLMENT FORM



Name (First, MI, Last)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Tech <input type="checkbox"/> AGR <input type="checkbox"/> State EE <input type="checkbox"/>			
Address		City	ST.	Zip	Age	Date of Birth Mo. / Day / Yr.
Phone Number (WK)	Phone Number (HM)	SS#		Date of Employment Mo. / Day / Yr.		
Location of Paying Office/Number		Employing Office		Annual Salary	Job Duty	Enroller Code

LONG TERM DISABILITY INSURANCE

☒ Check the box for the coverage you want based on your salary, either BASIC or BASIC+SUPPLEMENTAL. Rates are based on bi-weekly deductions.

SALARY UNDER \$18,000				SALARY \$28,000 - \$31,999					
		Your Age				Your Age			
		Under 40	40-49	50-59			Under 40	40-49	50-59
MONTHLY BENEFITS				MONTHLY BENEFITS					
<input type="checkbox"/> Basic - \$500	\$ 2.00	\$ 5.40	\$14.95	<input type="checkbox"/> Basic - \$700	\$ 3.00	\$ 8.10	\$21.65		
<input type="checkbox"/> Supplemental - \$400	\$.80	\$ 1.80	\$ 4.60	<input type="checkbox"/> Supplemental - \$700	\$ 2.00	\$ 4.50	\$ 9.90		
<input type="checkbox"/> Basic + Supplemental - \$900	\$ 2.80	\$ 7.20	\$19.55	<input type="checkbox"/> Basic + Supplemental - \$1,400	\$ 5.00	\$12.60	\$31.55		
SALARY \$18,000 - \$19,999				SALARY \$32,000 - \$39,999					
		Your Age				Your Age			
		Under 40	40-49	50-59			Under 40	40-49	50-59
MONTHLY BENEFITS				MONTHLY BENEFITS					
<input type="checkbox"/> Basic - \$600	\$ 2.50	\$ 6.75	\$18.30	<input type="checkbox"/> Basic - \$800	\$ 3.20	\$ 9.20	\$24.80		
<input type="checkbox"/> Supplemental - \$400	\$.80	\$ 1.80	\$ 4.60	<input type="checkbox"/> Supplemental - \$800	\$ 2.40	\$ 5.40	\$13.80		
<input type="checkbox"/> Basic + Supplemental - \$1,000	\$ 3.30	\$ 8.55	\$22.90	<input type="checkbox"/> Basic + Supplemental - \$1,600	\$ 5.60	\$14.60	\$38.60		
SALARY \$20,000 - \$23,999				SALARY \$40,000 - \$49,999					
		Your Age				Your Age			
		Under 40	40-49	50-59			Under 40	40-49	50-59
MONTHLY BENEFITS				MONTHLY BENEFITS					
<input type="checkbox"/> Basic - \$600	\$ 2.50	\$ 6.75	\$18.30	<input type="checkbox"/> Basic - \$1,000	\$ 4.40	\$11.70	\$31.20		
<input type="checkbox"/> Supplemental - \$500	\$ 1.20	\$ 2.70	\$ 6.90	<input type="checkbox"/> Supplemental - \$1,000	\$ 3.00	\$ 7.00	\$17.50		
<input type="checkbox"/> Basic + Supplemental - \$1,100	\$ 3.70	\$ 9.45	\$25.20	<input type="checkbox"/> Basic + Supplemental - \$2,000	\$ 7.40	\$18.70	\$48.70		
SALARY \$24,000 - \$25,999				SALARY \$50,000 and Over					
		Your Age				Your Age			
		Under 40	40-49	50-59			Under 40	40-49	50-59
MONTHLY BENEFITS				MONTHLY BENEFITS					
<input type="checkbox"/> Basic - \$600	\$ 2.50	\$ 6.75	\$18.30	<input type="checkbox"/> Basic - \$1,100	\$ 4.95	\$13.20	\$34.65		
<input type="checkbox"/> Supplemental - \$600	\$ 1.60	\$ 3.60	\$ 9.20	<input type="checkbox"/> Supplemental - \$1,400	\$ 4.90	\$10.50	\$25.20		
<input type="checkbox"/> Basic + Supplemental - \$1,200	\$ 4.10	\$10.35	\$27.50	<input type="checkbox"/> Basic + Supplemental - \$2,500	\$ 9.85	\$23.70	\$59.85		
SALARY \$26,000 - \$27,999									
		Your Age							
		Under 40	40-49	50-59			Under 40	40-49	50-59
MONTHLY BENEFITS									
<input type="checkbox"/> Basic - \$600	\$ 2.50	\$ 6.75	\$18.30						
<input type="checkbox"/> Supplemental - \$700	\$ 2.00	\$ 4.50	\$ 9.90						
<input type="checkbox"/> Basic + Supplemental - \$1,300	\$ 4.50	\$11.25	\$28.20						

TERM LIFE INSURANCE

☒ Check the box for the coverage you want based on your age. Rates are based on bi-weekly deductions.

Age	Benefit	Rate	Check Here	Benefit	Rate	Check Here	Age	Benefit	Rate	Check Here	Benefit	Rate	Check Here
Under 30	\$25,000	\$1.50	<input type="checkbox"/>	\$50,000	\$3.00	<input type="checkbox"/>	45 - 49	\$25,000	\$5.25	<input type="checkbox"/>	\$50,000	\$10.50	<input type="checkbox"/>
30 - 34	\$25,000	\$2.00	<input type="checkbox"/>	\$50,000	\$4.00	<input type="checkbox"/>	50 - 54	\$25,000	\$8.00	<input type="checkbox"/>	\$50,000	\$16.00	<input type="checkbox"/>
35 - 39	\$25,000	\$2.50	<input type="checkbox"/>	\$50,000	\$5.00	<input type="checkbox"/>	55 - 59	\$25,000	\$12.00	<input type="checkbox"/>	\$50,000	\$24.00	<input type="checkbox"/>
40 - 44	\$25,000	\$3.25	<input type="checkbox"/>	\$50,000	\$6.50	<input type="checkbox"/>							

☐ Children's coverage - \$5,000 per child (\$0.70) ☐ Children's coverage - \$10,000 per child (\$1.40)

Beneficiary Designation for Term Life Insurance

Name: _____ SS# _____
Address: _____ Relationship to the applicant _____
Beneficiary of the children's coverage will be the insured parent.

I request participation in the insurance plan offered by ReliaStar Life Insurance Company. I understand that, upon issuance of such insurance, I will become a Member of the NGAUS Insurance Trust. I understand that my employer, as a service performed for me, will make regular payroll deductions for the premiums. I direct that all experience credits declared as a result of my participation in the NGAUS Insurance Trust, after payment of Trust expenses, shall be paid to the National Guard Association of the United States or The National Guard Educational Foundation, as determined by the NGAUS Insurance Trust. No obligation shall be incurred because of information furnished unless and until coverage is approved by ReliaStar Life Insurance Company and the first premium is paid in full.

You must be actively at work for the National Guard at the time you enroll, not already insured in the Plan you are enrolling for (you can add Supplemental Disability Coverage if you are currently enrolled in Basic Disability), and you must not have previously been denied coverage by ReliaStar Life. Payroll deduction for your selected coverage must begin by the 2nd pay period after the open enrollment period ends. For all details of this Insurance Program, see the Technician booklet at your HRO.

Signature of Applicant ☒ Date _____ Mo. / Day / Yr.

Optional Benefits Are you interested in additional Group Term Life coverage for yourself? ☐ Yes ☐ No
Are you interested in Group Term Life coverage for your spouse? ☐ Yes ☐ No

FOR OFFICE USE ONLY Deduction amount for above coverages:		<input type="checkbox"/> New Coverage <input type="checkbox"/> Additional		
Basic LTD	Supplemental LTD			
Deduction Amount	Effective Date	1st Payroll Deduction	Transmittal Number HRO	Consec. Number

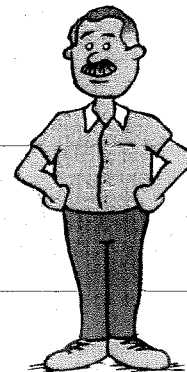
**Get the Facts on an
Important Part of Your
Benefits Package:**

**Fewer questions
when you
and/or your
spouse apply
within 60 days
of becoming
eligible.**

The Federal Long Term Care Insurance Program

"Long term care insurance empowers us to accept personal responsibility for our future security. I encourage you to request your free Information Kit, including an application and personalized premium quote!"

Kay Coles James
Director
U.S. Office of Personnel Management



Request your Information Kit and application today !

U.S. Office of Personnel Management
FERS Election Opportunities

FERS

Federal Employees Retirement System (An Overview of Your Benefits)

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For More Information

Previous editions are not usable.

RI 90-1

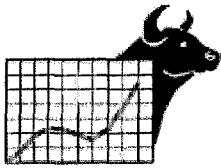
Revised April 1998

This booklet contains highlights of the Federal Employees Retirement System (FERS). It is not meant to provide a detailed explanation of all the plan provisions. The information is based on the law in effect at the time the booklet went to publication.

Under the Balanced Budget Act of 1997, Public Law 105-33 for fiscal year 1998, employee retirement contributions will increase as follows. Deductions for the Civil Service Retirement System and the Federal Employees Retirement System would be increased by 0.25% in January 1999, by an additional 0.15% in January 2000, and by 0.1% more in January 2001, for a total increase of 0.5%. These higher contribution rates would be in effect through 2002.

Additional retirement information and all publications of the U.S. Office of Personnel Management listed in this pamphlet are available on the Internet. OPM Website -- <http://www.opm.gov/asd/>.

For sale by the U.S. Government Printing Office
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Monthly Returns for the G, F, C, S, and I Funds

Returns were updated on August 2, 2006

Time Period	G Fund	F Fund	LBA Bond Index	C Fund	S&P 500 Stock Index	S Fund	Dow-Jones Wilshire 4500 Completion Index	I Fund	EAFE Stock Index
	%	%	%	%	%	%	%	%	%
2005									
Aug.	.37	1.23	1.28	(.90)	(.91)	(1.01)	(1.15)	3.23	2.53
Sep.	.36	(1.03)	(1.03)	.84	.81	.83	.76	3.68	4.45
Oct.	.36	(.75)	(.79)	(1.66)	(1.67)	(2.33)	(2.35)	(2.90)	(2.92)
Nov.	.36	.38	.44	3.75	3.78	4.72	4.67	2.44	2.45
Dec.	.45	.95	.95	.07	.03	.37	.48	4.64	4.65
2006									
Jan.	.36	.09	.01	2.66	2.65	6.70	6.57	6.14	6.14
Feb.	.36	.28	.33	.22	.27	(.98)	(.99)	(.27)	(.22)
Mar.	.36	(.93)	(.98)	1.29	1.25	3.84	3.81	3.33	3.30
Apr.	.44	(.19)	(.18)	1.35	1.34	.34	.41	4.83	4.78
May	.44	(.09)	(.11)	(2.87)	(2.88)	(4.36)	(4.32)	(3.87)	(3.88)
June	.44	.19	.21	.07	.14	.47	.29	.00	(.01)
July	.44	1.32	1.35	.65	.62	(2.79)	(2.82)	.98	.99
Last 12 Months	4.84	1.42	1.46	5.42	5.38	5.35	4.91	24.00	24.01

Percentages in () are negative.

The G Fund is managed internally by the Federal Retirement Thrift Investment Board. Assets of the F, C, S, and I Funds are managed externally. The Board currently has contracts with Barclays Global Investors, a U.S.-based subsidiary of Barclays PLC (a publicly listed financial services company based in London, England) to manage the F, C, S, and I Fund assets. The F, C, S, and I Funds invest in commingled trust funds, in which the assets of tax-deferred employee benefit plans are combined and invested together. The F, C, S, and I Funds and the Barclays funds are passively managed index funds.

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Attachment 2**Determining Eligibility for Agency Contribution**

If employee is appointed:	Agency contributions begin first full period in:
December 1, 2004 through May 31, 2005	December 2005
June 1 through November 30, 2005	June 2006
December 1, 2005 through May 31, 2006	December 2006
June 1 through November 30, 2006	June 2007
December 1, 2006 through May 31, 2007	December 2007



THRIFT SAVINGS PLAN ELECTION FORM

TSP-1

Use this form to start, stop, or change the amount of your contributions to the Thrift Savings Plan (TSP).

Before completing this form, please read the *Summary of the Thrift Savings Plan* and the instructions on the back of this form. Type or print all information. **Return the completed form to your agency personnel or benefits office.**

Note: To choose your investment funds, see the instructions in the General Information section on the back of this form.

I. INFORMATION ABOUT YOU

1. Name (Last) _____ (First) _____ (Middle) _____
2. Street Address _____ City _____ State _____ Zip Code _____
3. Social Security Number _____ - _____ - _____
4. () _____ - _____
Daytime Phone (Area Code and Number)
5. Office Identification (Agency and Organization) _____

II. START OR CHANGE YOUR CONTRIBUTIONS

To start or change the amount of your contributions to your TSP account, enter **either** a whole percentage of your basic pay per pay period (Item 6) **or** a whole dollar amount per pay period (Item 7). Skip to Section IV.

6. _____ .0% OR 7. \$ _____ .00

III. STOP YOUR CONTRIBUTIONS

To stop your contributions to the TSP, check Item 8 and complete Section IV. (If you are a FERS employee and you are eligible to receive Agency Automatic (1%) Contributions, those 1% contributions will continue. Read the instructions on the back.)

8. ☐ I want to stop contributing to my TSP account. I understand that my payroll contributions will stop no later than the first full pay period after my agency employing office receives this form.

IV. SIGNATURE

9. _____ 10. _____
Participant's Signature Date Signed (mm/dd/yyyy)

V. FOR EMPLOYING OFFICE USE ONLY

11. _____ 12. _____ 13. _____
Payroll Office Number Receipt Date (mm/dd/yyyy) Effective Date (mm/dd/yyyy)

14. _____
Signature of Agency Official

PRIVACY ACT NOTICE. We are authorized to request this information under 5 U.S.C. chapter 84. Executive Order 9397 authorizes us to ask for your Social Security number, which will be used to identify your account. We will use the information you provide on this form to process your TSP election. This information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. In addition, we may share the information with law enforcement agencies investigating

a violation of civil or criminal law, or agencies implementing a statute, rule, or order. It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries, and their attorneys. We may also disclose relevant portions of the information to appropriate parties engaged in litigation. You are not required by law to provide this information, but if you do not provide it, we will not be able to process your request.

ORIGINAL TO PERSONNEL FOLDER
Provide a copy to the employee and to the payroll office.

Form TSP-1 (1/2006)
PREVIOUS EDITIONS OBSOLETE

Summary of the Thrift Savings Plan

August 2005

